

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **28725**
Registrar's No. **48**

FILED SEP 12 1941

Primary Registration District No. **5628**

1. PLACE OF DEATH:

(a) County **Lawrence**
(b) City or town **Arrow, Mo. TWO**
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

3. (a) PRINT FULL NAME

Elizabeth M. Krug

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **M** Color or race **W**

6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Feb 16 1885**
(Month) (Day) (Year)

8. AGE: Years **86** Months **5** Days **19** If less than one day hr. _____ min. _____

9. Birthplace **Ills.** (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Carl Luke**

13. Birthplace **Ills.** (City, town, or county) (State or foreign country)

14. Maiden name **Emma Smith**

15. Birthplace **Arrow, Mo** (City, town, or county) (State or foreign country)

16. (a) Informant **M. Krug**

(b) Address **Arrow, Mo.**

17. (a) _____ (b) Date thereof **Aug 6 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Verona, Mo.**

18. (a) Signature of funeral director **W. Hersell**

(b) Address **Peiser City, Mo.**

19. (a) **Aug 5 1941** (b) **A. D. Kaulan MD**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Lawrence**
(c) City or town **Rural** (If outside city or town limits, write "RURAL")
(d) Street No. **Route 2** (If rural, give location)
(e) If foreign born, how long in U. S. A.? **7** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **4** year **1941** hour **83** minute **40** M.

21. I hereby certify that I attended the deceased from **May 27**, 19**41**, to **August 4**, 19**41** that I last saw him alive on **August 4**, 19**41** and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis**
Ischemic
Due to **Senility** Duration **8 yrs. 10 days**

Due to **Senility**

Other conditions (Include pregnancy within 3 months of death)
Ethel E. Rasmussen D.O.

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 6,

District File Number 941-1458

Date Filed SFD 9 1941

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No. 1512

P. O. Address Pine City, Mn

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.